Transforming Behavioral Health Care for Virginians

2025 Vision for Behavioral Health in the Commonwealth

All Virginians will…

… be able to access behavioral health care when they need it,

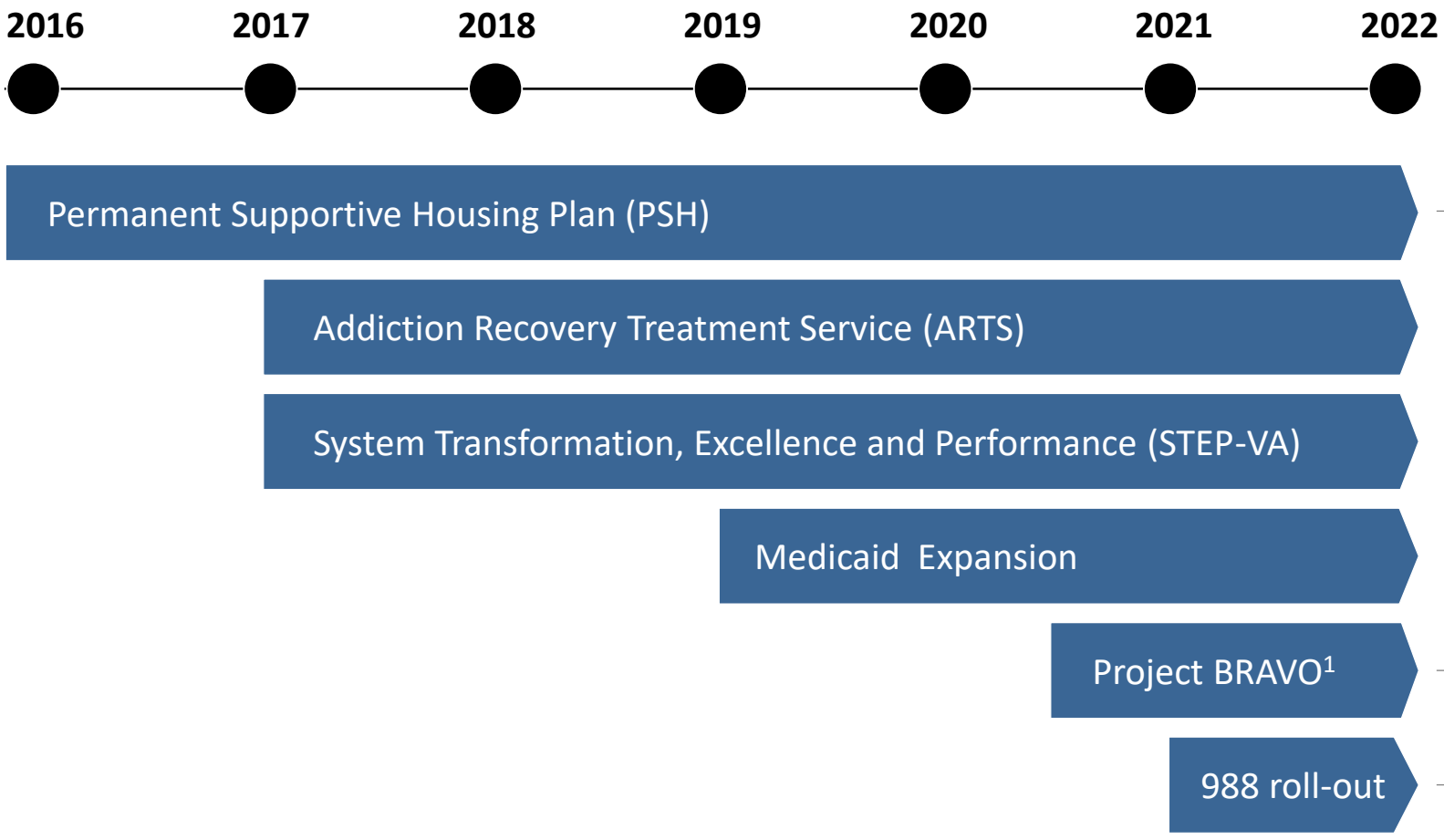
... have prevention and management services personalized to their needs, particularly for children and youth,

… know who to call, who will help, and where to go when in crisis, and

… have paths to reentry and stabilization when transitioning from crisis

Source: VA HHR

The Plan builds on the Commonwealth's progress across several initiatives



of individuals participating in PSH remained stably housed after transition[2]

of current BRAVO Phase 1 services adopted by Managed Care Organizations (MCOs)

in-state call answer rate following 988 roll-out[3]

1. Consists of the implementation of fully integrated behavioral health services that provide a full continuum of care to Medicaid members; DMAS Viginia.gov
2. Referring to the population served by PSH: Permanent Supportive Housing: Outcomes and Impact – November 2022 (virginia.gov)
3. DBHDS data, received November 28, 2022

Across the Commonwealth, access to Behavioral Health care remains a challenge

None of county is shortage area

Part of county is shortage area

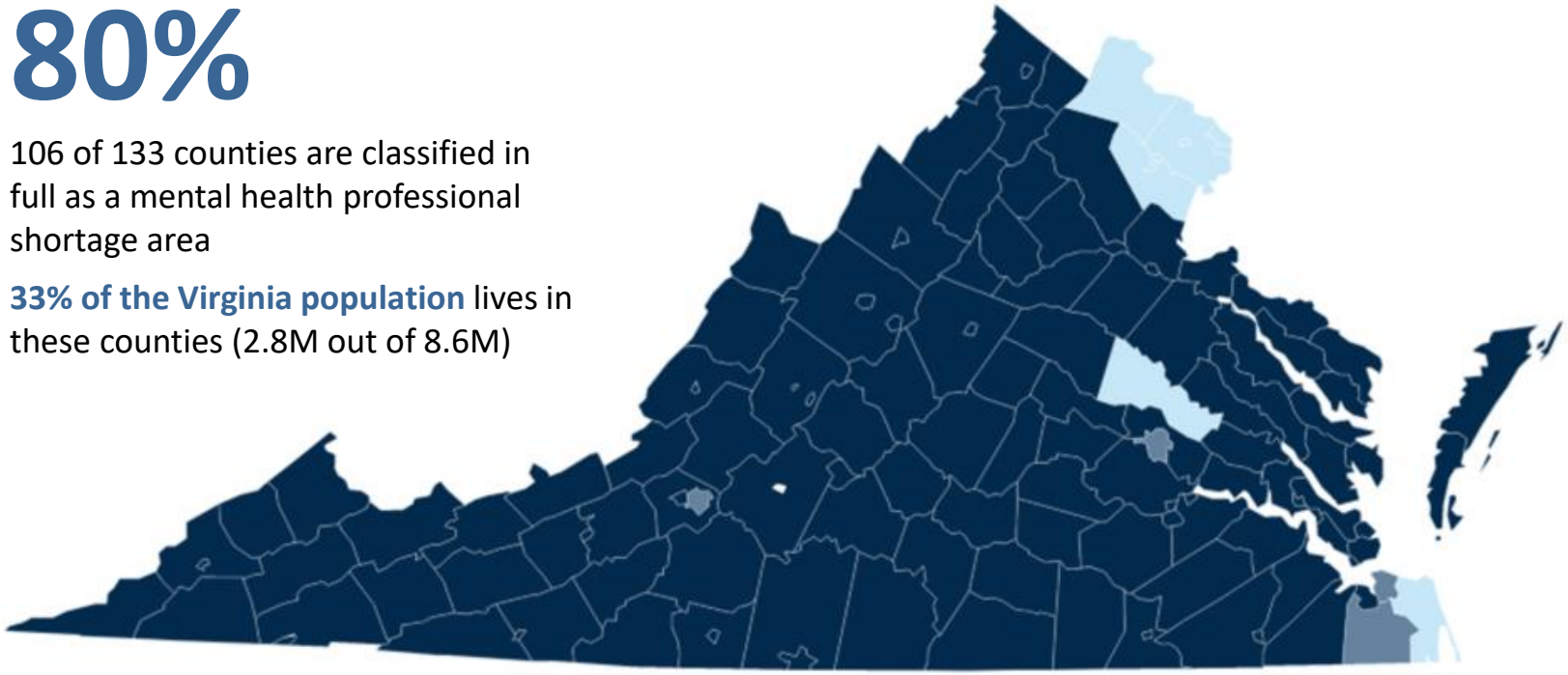
Full county is shortage area

Virginia Health Professional Shortage Areas by County, Mental Health, HRSA[1]

80%

106 of 133 counties are classified in full as a mental health professional shortage area

33% of the Virginia population lives in these counties (2.8M out of 8.6M)



Mental Health America rankings[2]

34th Access to Care

39th Mental Health Workforce Availability

1. Health Resources and Services Administration Mental Health Care Health Professional Shortage Areas, by State, as of September 30, 2022, data.HRSA.gov
2. State of Mental Health America, Access to Care Ranking 2023

Mental Health America ranks Virginia 14th out of 50 states for Adult Mental Health

Mental Health America, Adult Mental Health rankings

2022 → 2023 US Average
2022 - - - → 2023 Virginia Average

Worsening
Improving

14th 2023 Rank[1]

20th 2022 Rank[2]

		Better ← → Worse
Prevalence measures *Worsening in US and VA*	Virginia Adults with…	
	Any mental illness (AMI)	19.9% → 20.8%; 18.6% → 20.5%
	Substance use disorder	7.7% → 15.3%; 7.3% → 14.5%
	Serious thoughts of suicide	4.6% → 4.8%; 4.2% → 4.6%
Access barrier measures *Improving in US and VA*	AMI who are uninsured	10.8% → 11.1%; 6.5% → 12.4%
	AMI who did not receive treatment	54.7% → 55.9%; 47.4% → 54.7%

0% // 65%

1. Adult Ranking 2023, Mental Health America based on 2019-2020 data
2. Adult Ranking 2022, Mental Health America based on 2018-2019 data

Mental Health America ranks Virginia 48th out of 50 states for Youth Mental Health

Mental Health America, Youth Mental Health rankings

2022 → 2023 US Average
2022 - - - → 2023 Virginia Average

Worsening
Improving

21st 2022 Rank[1]

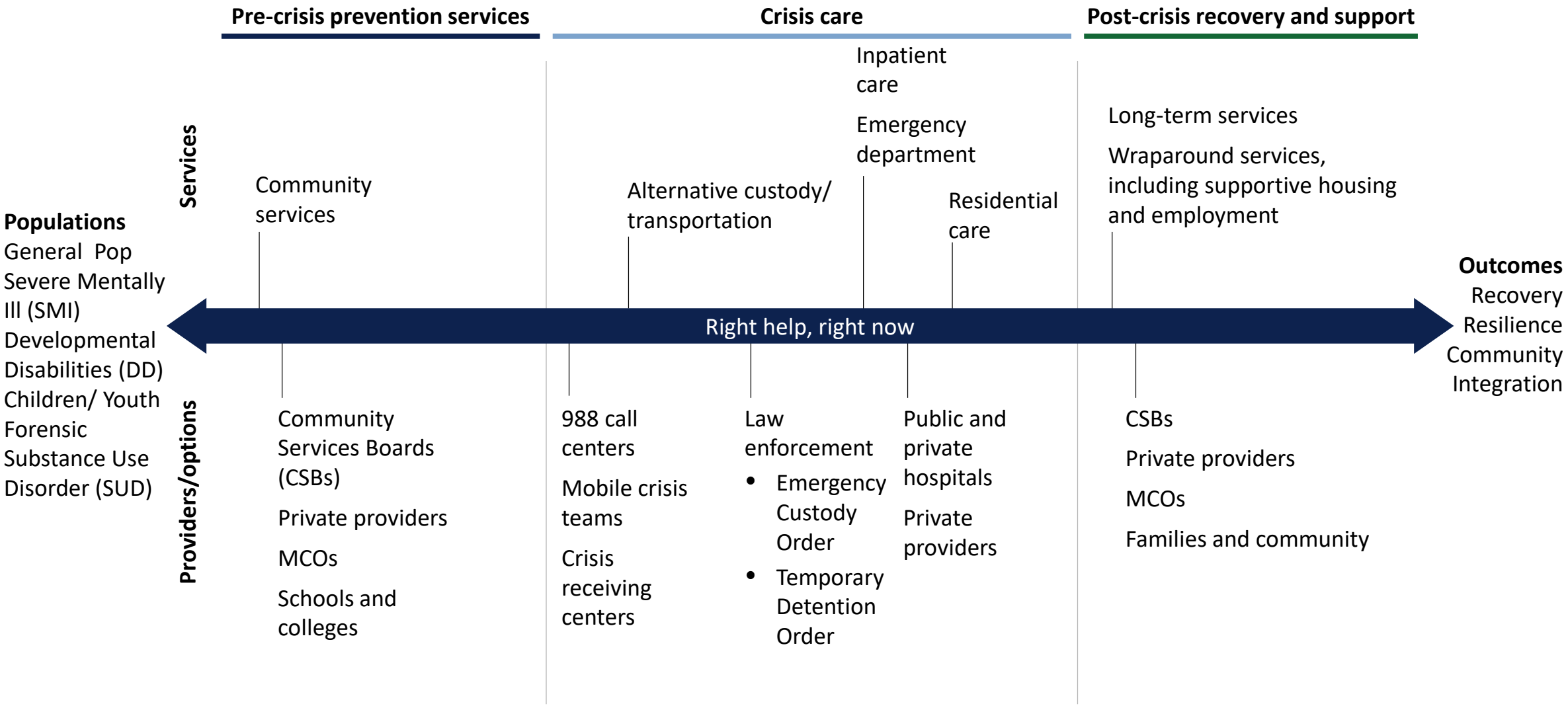
48th 2023 Rank[2]

		Better ← → Worse
Prevalence measures *Worsening in US and VA*	Virginia Youth with…	
	At least one major depressive episode (MDE)	15.1% → 16.4%; 15.6% - - - → 19.6%
	Substance use disorder	4.1% → 6.4%; 3.7% - - - → 7%
	Severe MDE	10.6% → 11.5%; 13% - - - → 15.7%
Access barrier measures *Worsening in VA*	MDE who did not receive mental health services	59.8% ← 60.3%; 55.2% - - - → 60.2%
	Private insurance that did not cover mental or emotional problems	8.1% → 10.3%; 6.4% - - - → 17%
		0% // 65%

1. Youth Ranking 2022, Mental Health America based on 2018-2019 data
2. Youth Ranking 2023, Mental Health America based on 2019-2020 data

Solutions to the Commonwealth's Behavioral Health crisis benefit from a system-wide perspective

Continuum of Behavioral Health Care



Source: VA HHR: DBHDS

The Commonwealth's Behavioral Health Plan – Executive Summary

We are taking a bold approach to address Virginia's behavioral health challenges

We will increase our focus on prevention and management of behavioral health conditions, getting help to Virginians as early as possible

This will reduce some of the strain on individuals, families, law enforcement, communities, and the behavioral health system itself

With greater upstream capacity, the public behavioral health system can focus more on Virginians most in need of acute care and support

We are doing this by scaling what is proven to work and implementing a multi-year behavioral health plan

We are prioritizing prevention and management by focusing on youth mental health, enhancing school-based services, and offering tele-behavioral health to students

We are ensuring all Virginians know **"who to call"** by investing in 988 crisis call centers

We are ensuring all Virginians know **"who will help"** if in crisis by scaling our Mobile Crisis Teams statewide which means behavioral health specialists can respond to someone in crisis in need of care

We are ensuring all Virginians know **"where to go"** so there is "no-wrong-door" to access mental health and substance use disorder care. We are building out our network of Crisis Receiving Centers

We are increasing support for reentry and stabilization by helping Virginians who are transitioning out of crisis reenter and rebuild within their communities, including through adding capacity in mental health group homes

We are doing this by breaking down barriers such as stigma and workforce constraints through new roles (e.g., peer support) and engagement of the broader ecosystem, including faith-based organizations, to help deliver community-based and prevention-focused behavioral health care for all Virginians

Source: VA HHR

The Commonwealth's Behavioral Health Plan is founded on six pillars

An aligned approach to BH that provides access to **timely, effective, and community-based care** to reduce the burden of mental health needs, developmental disabilities, and substance use disorders on Virginians and their families

1: We must strive to ensure **same-day care for individuals experiencing behavioral health crises**

2: We must **relieve the law enforcement communities' burden** while providing care and **reduce the criminalization of behavioral health**

3: We must **develop more capacity** throughout the system, going beyond hospitals, especially to enhance community-based services

4: We must **provide targeted support for substance use disorder (SUD)** and efforts to prevent overdose

5: We must **make the behavioral health workforce a priority**, particularly in underserved communities

6: We must **identify service innovations and best practices** in pre-crisis prevention services, crisis care, post-crisis recovery and support and develop tangible and achievable means to close capacity gaps

Source: VA HHR

Pillar 1: We must strive to ensure same-day care for individuals experiencing behavioral health crises

Initiatives	Year 1	Year 2	Year 3
1. Launch statewide 988 promotion	Message emergency department alternative, including across all VA law enforcement	Promote 988 given geolocation and routing capabilities	Complete linkages to all relevant BH services through 988 and other crisis entry points
2. Build up Mobile Crisis Team (MCT) capacity	Deploy regional MCT model with flexible central design based on funding provided	Ensure adequate staffing and resourcing, including training and technology (e.g., satellite phones for rural teams)	Evaluate and refine approach based on regional models (e.g., by subpopulation)
3. Enhance crisis receiving and stabilization capacity	Build out infrastructure based on funding provided Establish "CrisisNow VA" model CRC	Identify additional system-wide capacity needed and build out infrastructure	Complete build of infrastructure to address estimated required capacity
4. Develop outcomes-based payment approach	Define outcomes-based payment model and metrics (including within MCO procurement)	Ensure a meaningful portion of Medicaid reimbursement is tied to outcomes	Ensure commercial payor participation in outcomes-based approach
5. Develop technology infrastructure to enable crisis system	Develop Public Health Information Exchange with referral capability (e.g., automatic bed registry, mobile dispatch dashboard, ED interface)	Link crisis data platform to all relevant providers/MCOs and plan for linkage to 911	Integrate technology platform to enable outcomes reporting
Change management	*Engage stakeholders on crisis resources*	*Continue to engage stakeholders on crisis resources*	

Potential impact

Increase in utilization of 988 across crisis needs including SUD and other behavioral health crises in addition to suicide prevention (from 6k calls per month received to date)

Increase in appropriate utilization of crisis services (e.g., Mobile Crisis Teams) outside of inpatient settings

Realize "no wrong door" care across settings and geographies

Source: VA HHR, DBHDS data

Pillar 1: Planned infrastructure development across the crisis system builds towards estimated required capacity to respond to and stabilize BH crises

	Based on estimates of the current and planned crisis care infrastructure in VA[1]		Estimates of potential future crisis care infrastructure in VA (to build to the Arizona CrisisNow model)[2]		
	Current State (% of target[2])	Year 1[3] (% of target[2])	Year 2[4]	Year 3	Target state[5]
Mobile crisis teams (MCT)	36[1] (~50%)	70 (100%)	70 (100%)	70 (100%)	**70**
Crisis receiving center slots (<23 hours)	186[6] (~40%)	290 (~60%)	360-380 (~80%)	450-500 (100%)	**500**
Short-term crisis beds (1-5 days)	252 (~60%)	324 (~80%)	350-360 (~90%)	380-400 (100%)	**400**
Comprehensive Psychiatric Emergency Programs (CPEP)	1	4+	TBD	TBD	Expansion determined by success of pilot
Acute psychiatric inpatient beds	~3,200[7]	TBD	TBD	TBD	Dependent on buildout of CrisisNow VA

Near-term one-time investments to build infrastructure and capacity may be offset in the long-run with sustainable funding sources, including reimbursement of behavioral health services across payor sources (e.g., Medicaid, commercial health plans)

1. Based on November 2022 estimates, DBHDS; includes 90 total MCTs of which 40% are staffed
2. Based on estimates from the Crisis Resource Need Calculator, based on assumptions of:
   A. 230 crisis episodes require in-person response per 100,000 population on average
   B. National average rates of length of state, occupancy rates, and utilization rates
   C. Initial triage rates of 32% to mobile crisis teams (MCTs), 54% to crisis receiving facilities (CRFs), 14% to EDs
   D. Referral rates of 30% from MCTs to CRFs, 35% from crisis receiving facilities to short-term crisis beds, 25% from short-term crisis beds to inpatient care, 100% from ED to inpatient care
   E. Based on Arizona's 2014 implementation of its crisis system

Source: Crisis Resource Need Calculator; DBHDS

3. Includes Governor's amended budget proposals, across 23 CSUs, 37 CITACs, and 27 Crisis receiving centers
4. Assumes Year 2 investment for 50% additional capacity to build on Year 1 capacity towards target state
5. Target state is based on estimates from the Crisis Resource Need Calculator of minimum capacity required across settings to manage estimated number of crisis episodes requiring in-person response across the state population (based on observed average of 230 crisis episodes per 100,000 population)
6. Estimate as of November 2022 based on initial Chapter 2 budget
7. Includes psychiatric bed capacity across state and private hospitals (does not reflect staffing levels)

Pillar 2: We must relieve the law enforcement communities' burden while providing care and reduce the criminalization of behavioral health

Initiatives	Year 1	Year 2	Year 3
1. Promote co-responder models	Survey CSBs to establish fact base on co-response models across law enforcement (LE) departments in VA (e.g., current build-out and funding models) Identify potential reimbursement options	Scale co-responder model to additional LE departments Integrate co-responder strategy with the build-out of overall mobile crisis team as part of the broader crisis system infrastructure	
2. Provide training and support to CSBs (e.g., pre-screener role)	Understand variation in TDO issuance across CSBs including pre-screener role Conduct state-wide training and oversight across CSBs and pre-screeners	Review pre-screening role, including professional requirements	Address pre-screening role, including licensure / certification
3. Reduce adminis-trative burden for pre-screeners	Establish Public Health Information Exchange (in coordination with crisis pillar) Create transparency through real-time TDO data (e.g., dashboard for the TDO task force)	Add private provider information to Public Health Information Exchange	
4. Scale alternative transport, custody, and treatment services	Develop change management plan for DBHDS and CRCs to enable "no wrong door" Launch mental health transportation pilot Support off-duty officer program Implement alternative custody where appropriate	Coordinate with crisis pillar to scale CRC model and conduct LE and other stakeholder site visits Scale alternative transport programs	
Change management	*Engage law enforcement on crisis resources*	*Continue to engage law enforcement and additional stakeholders on crisis resources*	

Potential impact

Reduce TDOs (from 21,104 in SFY2022)

Increase consistency across CSBs in issuance of TDOs (e.g., reduce variation across pre-screeners from ~10-70% across CSBs)

Reduce time that law enforcement is involved in BH response from average ~51 hours to time of transport

Source: VA HHR, DBHDS data

Pillar 3: We must develop more capacity throughout the system, going beyond hospitals, especially to enhance community-based services

Initiatives	Year 1	Year 2	Year 3
1. Expand community-based models	Plan for CCBHC[1] Demonstration Program (e.g., data infrastructure, payment system)	Train 12 CSBs (e.g., CCBHC) Establish data-sharing approach Assess CSB shared savings Ease CSB billing	Train 28 CSBs (e.g., CCBHC) Ensure DD, emergency, other services continue across CSBs
2. Expand care integration	Assess landscape of non-BH providers Expand BH supports in specialty provider settings	Build on Virginia Mental Health Access Program Support inclusion of primary care supports in BH settings Explore creation of BH reserve corps	
3. Expand tele-behavioral health access	Determine need for broadband to support telehealth objectives Launch telehealth strategy across behavioral health continuum	Address broadband needs identified to support telehealth Assess telehealth access for tiered services in schools	
4. Increase youth BH support	Scale school-based mental health trainings and services Expand Medicaid funded school-based services and support Phase II of BRAVO on children and youth		
5. Expand services for DD population	Increase rates for waiver services Reduce priority 1 waitlist	Assess performance and address opportunity improvement areas Continue to reduce priority 1 waitlist	
6. Enhance re-entry and stabilization services	Scale Permanent Supportive Housing and Mental Health Group Homes Identify additional programs / services to potentially scale	Expand and support additional community reintegration needs (e.g., employment, care coordination, group homes)	

Potential impact

Decrease in wait times for BH care

Decrease in adults with any mental illness (AMI) who did not receive treatment

Increase in individuals receiving BH care at parity, regardless of insurance status

Increase in access to BH screening, early intervention, and referral at specialty provider setting

Increase in integrated care (BH/physical health integration)

Increase in children, youth that need treatment, getting access to care

Decrease in state psychiatric hospital readmissions and utilization (from current utilization rate of 95% to state target of 85%)

Shift to sustainable funding sources over time

1. Certified Community Behavioral Health Clinics (CCBHCs)

Source: VA HHR, DBHDS data

Pillar 4: We must provide targeted support for substance use disorder (SUD) and efforts to prevent overdose

Initiatives	Year 1	Year 2	Year 3
1. Develop mobile treatment and crisis response specific for SUD	Develop substance use journeys to pressure test against crisis system design Develop strategy for mobile crisis response for SUD	Expand to additional pilot geographies Develop and incorporate substance use specific metrics into crisis system	Launch model statewide Support integration of SUD into crisis delivery
2. Empower communities in addressing the SUD crisis	Support communities (including Community Coalitions) in prevention-focused efforts Launch wellness and resiliency campaign	Define and begin tracking specific impact measures Expand wellness and resiliency campaign	Build in accountability mechanisms
3. Target programs with the greatest potential to prevent adverse outcomes	Assess potential for harm reduction Expand Naloxone access and training	Build capacity to link state social and health services for harm reduction	Align incentives across state entities to support standards
4. Expand innovative programs for proven and effective treatments across the continuum	Convene cross-agency planning for evidence-based treatment pilots Expand delivery of evidence-based treatments	Expand pilots by archetype (e.g., rural, families) for programs (e.g., Peer Mentor Program with Child Welfare)	Scale programs statewide
5. Reduce barriers to recovery	Assess current policies and levers to reduce barriers to recovery (e.g., peer roles, transition programs) and expand or pilot approaches	Expand pilots for specific subpopulations (e.g., non-traditional supports)	Scale programs statewide

Potential impact

Increase access to timely care for individuals seeking treatment for substance use in prevention and management settings

Increase access for individuals experiencing substance use-related crises

Reduce rates of relapse through improved peer support resources and housing supports for individuals in recovery

Source: VA HHR

Pillar 5: We must make the behavioral health workforce a priority, particularly in underserved communities

Initiatives	Year 1	Year 2	Year 3
1. Increase recruiting by reducing constraints where appropriate	Define objectives (e.g., peer hiring) & review parameters for licensure requirements	Implement changes and relaunch recruitment	
2. Work towards parity in rates and compensation across private and public sectors	Understand opportunity across roles and potential sources (e.g., CCBHC opportunity for CSBs) and create roadmap to parity Increase funding for non-direct care staff to increase bed capacity at public facilities	Determine any required administrative changes to enable reimbursement Act on roadmap created in year 1	Implement updates to compensation structures Assess early impacts and outcomes of first initiatives
3. Increase capabilities for non-BH providers to provide BH care	Prioritize target roles and initiate engagement campaign with providers and educators	Design and launch training programs to upskill additional providers on BH care	Collect feedback from providers and educators and refine program
4. Increase pipeline of incoming BH providers through educational opportunities and "grow your own" roles	Fund loan repayment programs for BH providers Increase BH residency slots Develop a provider training strategy	Engage providers and educators in "grow your own" training opportunities	Review, refine and expand programs as needed Assess early impacts and outcomes of first initiatives
5. Reduce administrative burden for providers	Establish cross-agency workgroup to identify and address key pain points	Implement streamlined processes for priority roles in public BH system	Review, refine and expand program
6. Support public campaigns to increase attractiveness of BH roles	Collaborate with state and external stakeholders on public campaigns aimed to increase attractiveness of BH provider roles	Assess initial impact, refine and scale programs	

Potential impact

Enhance recruitment: Increase number of individuals in existing roles in the field providing services

Improve retention: Ensure retention across all roles and improve the attractiveness of roles

Ensure expansion: Expand the service of non-BH providers via integrated care

Source: VA HHR, DBHDS data

Pillar 6: We must identify service innovations and best practices in prevention and management, crisis services, re-entry services and develop tangible and achievable means to close capacity gaps

Initiatives	Year 1	Year 2	Year 3	Potential impact
1. Enhance administrative processes and provider trainings to reduce provider burden	Convene agencies with directive to establish uniform standards for BRAVO providers, e.g., • Provider (e.g., QMHP) training curriculum • Medicaid MCO administration practices Develop public education campaign to build BH system awareness for individuals and providers	Work with Medicaid MCOs to coordinate delivery of common qualified mental health professionals (QMHP) training Work with Medicaid MCOs to improve administrative processes Launch BH public education campaign	Evaluate effectiveness of QMHP training Determine additional workforce focus for training standardization Determine additional administrative efficiencies for Medicaid MCOs and define timeframe for implementation	Improve service delivery quality and increase access to services Increase provider satisfaction by reducing administrative burden and overhead for providers Make progress towards aspirations of BH parity
2. Assess and align BH provider network to address service gaps	Convene agencies to develop an analytical approach to determine BH network and workforce gaps Establish model to measure BH network adequacy and determine priorities	Determine workforce network capacity priorities Implement MCO BH network accessibility and adequacy standards through re-procurement	Determine workforce network capacity priorities Monitor MCO performance on new network adequacy contract requirements, refine over time	
3. Develop outcome-based payment strategies	Design and plan for launch of CCBHC model (e.g., develop reimbursement model) Create an outcomes-based payment model that holds MCOs accountable for BH quality and outcomes	Build out CCBHC reimbursement model Award Medicaid MCO contracts that include BH outcomes-based payment standards (e.g., that increase YOY)	Refine and scale CCBHC reimbursement model Continually refine and strengthen BH outcomes-based payment model in Medicaid MCO contracts	
4. Increase youth BH support through specialized programs in Medicaid managed care	Explore design options for specialized program/services for children and youth BH through Medicaid managed care Facilitate DSS/DMAS collaboration; focus on Model of Care for youth and notification processes	Determine path forward for children/youth BH (e.g., Model of Care, specialized programs/services)	Implement new programs and strategies	
5. Work with commercial health plans to enhance BH service coverage	Determine opportunities and strategies to increase coverage for BH services in commercial insurance (e.g., enhancing Essential Health Benefits)	Implement changes to increase coverage of BH services and establish processes for managing and monitoring	Implement management and monitoring processes	

Source: VA HHR, DBHDS data

The Commonwealth's approach to Behavioral Health is holistic and spans the BH care continuum

	Pre-crisis prevention services	Crisis care	Post-crisis recovery and support
Pillar 1: We must strive to ensure same-day care for individuals experiencing **behavioral health crises**		• Launch statewide 988 promotion • Build up Mobile Crisis Team (MCT) capacity • Enhance crisis receiving and stabilization capacity • Develop outcomes-based payment approach for crisis • Develop tech. infrastructure to enable crisis system	
Pillar 2: We must **relieve law enforcement communities' burden** and reduce criminalization of mental health		• Promote co-response models • Provide training and support to CSBs (pre-screener) • Reduce administrative burden for pre-screeners • Scale alternative transport, custody, and treatment	
Pillar 3: We must develop **more capacity** throughout the system, going beyond hospitals, especially community-based services	• Expand tele-behavioral health access • Increase youth BH support (e.g., school-based) • Expand services for IDD/ DD population		• Enhance re-entry and stabilization services
	• Expand community-based models		
Pillar 4: We must provide targeted support for **substance use disorder** and efforts to prevent overdose	• Empower communities to address SUD crisis • Target programs with potential to prevent adverse outcomes	• Develop SUD mobile treatment and crisis response	• Reduce barriers to recovery
	• Expand innovative programs for proven and effective treatments		
Pillar 5: We must make the BH **workforce** a priority, particularly in underserved communities	• Increase recruiting by reducing constraints • Work towards parity in rates and compensation • Increase pipeline through educational opportunities (e.g., fund loan forgiveness)	• Increase capabilities of non-BH providers • Reduce administrative burden for providers • Support public campaigns to increase attractiveness of roles	
Pillar 6: We must identify **service innovations** and best practices in prevention and management, cris-is services, re-entry services and develop tangible and achievable means to close capacity gaps	• Enhance administrative processes and provider trainings to reduce provider burden • Assess and align BH provider network to address service gaps • Develop outcome-based payment strategies • Increase youth BH support through specialized programs in Medicaid managed care • Work with commercial health plans to enhance coverage for BH services		

Source: VA HHR, Governor's proposed 2024 budget

The Governor's proposed additional spend and budget language amendments for 2024 (Total over $230M)

$xx Proposed additional budget spend (2024)

	Pre-crisis prevention services	Crisis care	Post-crisis recovery and support
Pillar 1: We must strive to ensure same-day care for individuals experiencing **behavioral health crises**		• Expansion of mobile crisis units: **$20M**[3] • Build out infrastructure for crisis receiving: **$58.3M**[3] • Innovative hospital-based psychiatric emergency alternatives: **$20M** **$98M**	
Pillar 2: We must **relieve law enforcement communities' burden** and reduce criminalization of mental health		• Mental health transportation pilot: **$4.1M** • Support off duty officer program: **$1M** • Flexible use of mental health pilot program funds • Dedicated sworn officers for ECO/TDO : **$4M** **$9M**	
Pillar 3: We must develop **more capacity** throughout the system, going beyond hospitals, especially community-based services	• Telehealth services for k-12 and higher-ed: **$9M** • Expansion of school-based mental health services: **$15M** • Plan for CCBHC Demo program: SAMSA grant in progress • CSB training: **$1M** CDC Grant **$25M**		• Expand housing options for the SMI population: **$8M** **$8M**
	• Improvements to waiver administration system: **$0.5M** • Fund 500 additional DD waiver slots: **$15.1M**	• Increase rates for personal care, respite, and companion services: **$41.6M**[2] **$57M**	
Pillar 4: We must provide targeted support for **substance use disorder** and efforts to prevent overdose	• Campaign to reduce fentanyl deaths: **$5M** • Increase access to Naloxone: **$3M**[3] • Designate portion of opioid settlement fund for Fentanyl: **$7M** **$15M**		• Improve access to peer recovery services in Medicaid
Pillar 5: We must make the BH **workforce** a priority, particularly in underserved communities	• Additional funding for state facility staff: **$9M**[3] • Additional psychiatric residency slots: **$1M**[3]	• Additional Loan repayments for psychiatric nurse and nurse practitioners: **$5M** • Loan repayment for child and adolescent psychiatric providers: **$3M**[3] **$18M**	
Pillar 6: We must identify **service innovations** and best practices in prevention and management, crisis services, re-entry services and develop tangible and achievable means to close capacity gaps	• Administrative costs for managed care organization re-procurement: **$4.3M**[1] • MCO contract changes to be proposed in 2024 General Assembly session for approval **$4M**		

1. $4.3M includes total funding for Medicaid procurement (and not only BH components) 2. Includes DD and CCC Plus populations 3. Amounts are incremental to existing budget

Source: VA HHR, Governor's proposed 2024 budget